U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 09 September 2005

Case No: 2004-BLA-06268

In the Matter of

JAMES J. PINKSON,
Claimant,

v.

PEABODY COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Respondent.

APPEARANCES:

Sandra M. Fogel, Esquire
For the claimant

Scott A. White, Esquire
Richard H. Risse, Esquire
For the employer

BEFORE: STEPHEN L. PURCELL
Administrative Law Judge

DECISION AND ORDER — AWARDING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 et seq. ("the Act"). Benefits under the Act are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201 (2004).

On May 7, 2004, this case was referred to the Office of Administrative Law Judges for a formal hearing. (DX 47). Following proper notice to all parties, a hearing was held on April 13, 2005 in Carbondale, Illinois. The Director's exhibits 1-47, Claimant's exhibit 1, and Employer's exhibits 1-20 were admitted into evidence pursuant to 20 C.F.R. § 725.456. Tr. 8, 9, 11. Claimant and Employer were both allowed to submit post-hearing evidence, and Claimant's exhibit 2 and Employer's exhibits 19 and 20 are hereby admitted into evidence. The parties had full opportunity to present closing arguments in the form of post-hearing briefs. Employer's closing argument was received on August 30, 2005, and Claimant's post-hearing brief was received August 31, 2005.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, the arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, CX, and EX refer to the exhibits of the Director, Claimant, and Employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. Whether the instant claim is a "subsequent" claim;

2. Whether the claim was timely filed;

3. Whether the miner has pneumoconiosis as defined by the Act and regulations;

4. Whether the miner's pneumoconiosis arose out of coal mine employment;

5. Whether the miner is totally disabled; and

6. Whether the miner's disability is due to pneumoconiosis?

DX 47; Tr. 5-7.

The Employer also contests another issue that is identified in item 18 on the list of issues. DX 47. This issue is beyond the authority of an administrative law judge and is preserved for appeal. The Employer conceded 19 years of coal mine employment. Tr. 7.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

Claimant, James J. Pinkston, filed a claim for black lung benefits which was received by the Department of Labor in Harrisburg, Illinois on January 30, 1991. DX 1. In a letter dated February 7, 1991, Claimant was informed that his application was being processed, and he was asked to schedule a medical examination with the UMWA Hospital in West Frankfort, Illinois. *Ibid*. A Notice of Claim was sent that same date to Peabody Coal Company informing it of the receipt of the miner's claim. *Ibid*. In a letter dated April 2, 1991, Claimant was informed by the Department of Labor that it had not yet received the evidence needed to decide his black lung claim and that the claim would be considered denied by reason of abandonment if he failed to respond within 30 days from the date of the letter. *Ibid*. In a letter dated May 22, 1991, Peabody Coal Company was informed that the claim of James J. Pinkston had been denied by reason of abandonment based on his failure to respond to the April 2, 1991 letter. *Ibid*.

Mr. Pinkston filed his current claim for black lung benefits on February 12, 2002. DX 5. On November 26, 2002, a Proposed Decision and Order denying the claim was issued by the District Director. DX 31. On December 12, 2002, Claimant filed a request for a formal hearing regarding the denial of his claim. DX 32. The claim was forwarded to the Office of Administrative Law Judges by the District Director on March 19, 2003, but the case was subsequently remanded on September 5, 2003 by Administrative Law Judge Edward Terhune Miller after Claimant sought a continuance to allow for further development of the evidence. DX 35, 37. On May 7, 2004, the claim was again returned to the Office of Administrative Law Judges for a formal hearing. DX 47.

Claimant was born on August 25, 1934 and was 70 years of age at the time of the formal hearing. DX 5; Tr. 16. He married Willidean Hise on May 13, 1960, and they have a thirteen year old adopted daughter, Zara Jo, who was born on March 26, 1992. DX 5, 11; Tr. 16-17.

Mr. Pinkston is now retired but previously worked as a coal miner initially for Island Creek Coal Company and then for Peabody Coal Company. Tr. 17-18. He worked for Peabody between 1970 and 1988, and his last job was Maintenance Foreman working underground. Tr. 18. He averaged eight hours per day underground and worked between five and seven days a week. *Ibid*. He worked both before and after his eight-hour shift completing reports for a total of 9 to 10 hours a day. Tr. 19. He performed a lot of manual labor even though he was a supervisor. *Ibid*. He lifted up to 100 pounds in performing his duties, and he also had to crawl around and under machines and walk between 100 and 1,000 feet. Tr. 20-21. Walking, crawling, and lifting were difficult because of his breathing problems. Tr. 21-22.

Claimant went on disability in 1988 because of knee replacements. Tr. 22. He filed an application for black lung benefits in 1991 but never followed up on it because he was told that if he was awarded black lung benefits his pension would be reduced by the amount of the black lung award. Tr. 22-23. He was not represented by counsel at that time and has only an eighth grade education. Tr. 23

Mr. Pinkston first began to experience shortness of breath in the 1980's and was told by Dr. Crouse, who performed annual physical examinations of Claimant, that his breathing was "real low." Tr. 23. He becomes short of breath any time he exerts himself, including walking and climbing stairs. Tr. 24. Claimant is currently treated by his family doctor, Larry Jones, and Dr. Jones referred him to a lung specialist, Dr. Dave, in the Carbondale Clinic. Tr. 24-25. Dr. Jones has been treating Claimant for the past 15 years and has prescribed medication and a nebulizer for his breathing problems. Tr. 25. Claimant started seeing Dr. Dave around 2001, and he prescribed Advair and a Combivent inhaler, as well as Prednisone periodically. *Ibid*. Mr. Pinkston was diagnosed with lung cancer in 2002 and underwent surgery in July of that same year. Tr. 26. He had a lung resection of the upper lobe. *Ibid*. In December 2004, a CAT scan revealed "spots" and he underwent a lung biopsy in January 2005. *Ibid*. Claimant is on medication for high blood pressure and diabetes, does not have heart disease to his knowledge, has no known allergies, and believes he was told by Dr. Dave that he is totally disabled due to coal workers' pneumoconiosis. Tr. 27-28. He does very few chores around the house and can walk maybe 100 feet on a level surface. Tr. 28. He rides a stationary bicycle for exercise every day for 15 or 20 minutes. Tr. 29. He smoked about one-half to a pack of cigarettes on a regular basis from about age 20 until he quit in January 1981. Tr. 29-30.

Mr. Pinkston has not worked anywhere since leaving Peabody Coal Company. Tr. 30. He last worked at the Eagle 2 mine in Shawneetown, Illinois and began work there in about 1970 as a repairman. Tr. 31. He became a supervisor in 1974 or 1975. *Ibid*. He spent most of his day going around checking on the work being performed by the men he supervised. Tr. 36. He traveled from site to site on man trips which operated on a rail system. *Ibid*. He worked 640 feet underground in a mine that was at least six square miles in area. Tr. 37. He lifted 100 pounds and walked 1,000 feet or more daily. Tr. 38. He is 5' 8 ½" tall and weighs about 220 pounds. *Ibid*.

Claimant was diagnosed with lung cancer in May 2002 and underwent surgery that July. Tr. 39. He saw Drs. Gould and Domingo to be evaluated for either chemotherapy or radiation and was told he did not need it. *Ibid*. No one has recommended either therapy in follow-up. *Ibid*. He had his first knee surgery in May or June 1988 right after he stopped working. Tr. 40. He stopped working so he could have the surgery, and had his second knee replacement one year later. *Ibid*. He never asked his doctors whether his lung cancer may have been related to his coal mine work. *Ibid*. Drs. Gould and Domingo were oncologists, and Claimant's lung surgery was done by Dr. Rubilotsky, a cardiac surgeon. Tr. 40-41.

Coal Mine Employment

The duration of a claimant's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. Claimant bears the burden of proof in establishing the length of his coal mine work. *See Shelesky v. Director, OWCP*, 7 BLR 1-34, 1-36 (1984); *Rennie v. U.S. Steel Corp.*, 1 BLR 1-859, 1-862 (1978). On his application for benefits, Mr. Pinkston alleged 21 years of coal mine employment. DX 5. The Employer conceded 19 years of coal mine employment. After a review of the record, I accept the

Employer's concession and find that Mr. Pinkston has established 19 years of coal mine employment.

Mr. Pinkston testified that his last coal mining job was as a supervisor, a position he held until 1988, when he left so he could undergo knee surgery. He last worked for Peabody Coal Company. As a supervisor, he spent eight hours a day underground, walked 1,000 feet, and lifted up to 100 pounds. Mr. Pinkston had to crawl around and under machines during the course of his duties. He has not worked at all since he left Peabody Coal Company.

Responsible Operator

The Employer has not contested that it is the responsible operator in this case. An employment history form completed by Claimant shows that Mr. Pinkston worked for Island Creek Coal Company from October 1969 to October 1970 and then worked for Peabody Coal Company from October 1970 to 1990. DX 7. Claimant testified that he worked for Island Creek Coal Company for one year, began working for Peabody Coal Company in 1970, and left Peabody Coal Company in 1988 to undergo knee surgery. The record and testimony establish that the claimant did not work as a coal miner after that date. The Social Security records confirm that Claimant worked for Peabody Coal Company from 1970 through 1988 and that any employment that followed was not coal mine employment. DX 9. Consequently, I find that Peabody Coal Company is the properly designated responsible operator.

Dependents

Employer withdrew its controversion of the issue of dependency at the formal hearing. Tr. 41. Pursuant to §§ 725.204 and 725.205, I find that Willidean Pinkston qualifies as the miner's spouse and dependent because the marriage certificate proves they are married, and Claimant testified at the hearing that they reside in the same household. DX 10, 2. Similarly, I find that Zara Jo Pinkston is the adopted daughter of Claimant and qualifies as the miner's dependent child for purposes of benefits augmentation. DX 11. Consequently, I find that Claimant has two dependents for purposes of augmentation of benefits.

Subsequent Claim

Claimant asserts that the claim he filed on March 11, 2002 (DX 5) is his "original" claim and the provisions of 20 C.F.R. § 725.309 relating to "subsequent" claims are inapplicable since the claim he filed on January 30, 1991 (DX 1) was deemed abandoned and never decided on the merits. In support of his position, Claimant relies on *Crowe v. Director, OWCP*, 226 F.3d 609 (7th Cir. 2000).

In *Crowe*, the Seventh Circuit found that a 1981 claim filed by an illiterate *pro se* miner who had been given misinformation about his entitlement to black lung benefits by the Social Security Administration did not qualify as that claimant's "original" claim because it had been denied solely on procedural grounds and without any discussion or ruling on the merits. *Crowe v. Director, OWCP*, *supra*. at 613. The court therefore reversed and remanded the Board's decision which affirmed an Administrative Law Judge's denial of the miner's 1990 claim

because he had failed to establish a change in condition since the 1981 claim as required by § 725.309. *Id*. at 614. The court's decision in *Crowe* does not support Claimant's contention.

As the court itself noted, its holding in *Crowe* was expressly limited to the specific and unique facts of that case. *Id.* at 614, n. 6. Unlike Crowe, Claimant is not illiterate. His duties as a Maintenance Foreman with Peabody Coal Company between 1974 and 1988 required, as he himself testified, that he prepare and file multiple reports on a daily basis. Similarly, the forms completed and filed by Claimant with the Department of Labor in both claims belie his counsel's efforts to portray him as someone who was either confused or ill informed about the claims process. Indeed, based on my opportunity to observe and listen to him during the formal hearing in Carbondale, Illinois, I found him to be quite articulate and well informed, despite the fact that he has only an eighth grade formal education. In addition, while Claimant has alleged that he did not pursue his 1991 claim because "they told me that if I was awarded black lung that . . . it would come off my pension" (Tr. 23), unlike Crowe, who was told by government officials at the Social Security Administration that he need not do anything because he would automatically qualify for black lung benefits if he qualified for Social Security benefits, Mr. Pinkston never explained who "they" were and he affirmatively *chose* not to pursue his claim for black lung benefits. Given these and other differences between the facts of this case and those described by the Seventh Circuit in *Crowe*, I find the holding of that case inapplicable to Mr. Pinkston's claim.[1] I thus find that the claim filed by him on February 12, 2002 is a "subsequent" claim and the provisions of 20 C.F.R. § 725.309 are applicable thereto.[2]

Timeliness

Section 725.308 provides, in relevant part, that a claim for benefits shall be filed within three years after a medical determination of total disability due to pneumoconiosis has been communicated to the miner. 20 C.F.R. § 725.308(a). The instant claim for benefits was filed by Mr. Pinkston on February 12, 2002. DX 5. Nothing in the record before me suggests that Claimant was ever informed he was totally disabled by pneumoconiosis more than three years before the date upon which this claim was filed, and Employer has offered no argument to the contrary. I therefore find the claim is timely.

[1] I also note that, subsequent to the Seventh Circuit's decision in *Crowe*, the Department added a provision to subsection (c) of 20 C.F.R. § 725.409 "to clarify the effect of a denial of a claim by reason of abandonment on a subsequent claim filed by the same individual." *Department of Labor, Employment Standards Administration, Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended,* 65 FR 79920, 79987 (Dec. 20, 2000). That regulation now states, in relevant part: "For purposes of § 725.309, a denial by reason of abandonment shall be deemed a finding that the claimant has not established any applicable condition of entitlement." 20 C.F.R. § 725.409(c) (2004).

[2] Even though I have found that § 725.309 applies in this case, that fact is virtually meaningless with respect to the adjudication of this claim. If the subsequent claim filed by Mr. Pinkston on February 12, 2002 were deemed to be an "original" claim, it would be incumbent upon Claimant to establish that: (1) he has pneumoconiosis; (2) the disease arose from coal mine employment; (3) he is totally disabled; and (4) his disability is caused by pneumoconiosis. Since Mr. Pinkston's 1991 claim is deemed to have been denied because he failed to establish any applicable condition of entitlement, to prevail in his current claim he must now present evidence which is sufficient to establish each of these same four elements.

Medical Evidence

A. X-Ray reports[3]

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Qlty.	Interpretation
DX 15	5-1-02	5-1-02	Majmudar	1	p/r, u; 0/1
DX 17	5-1-02	6-18-02	Gaziano, B	2	Under exposed
DX 26	5-1-02	7-18-02	Wiot, BCR, B	1	No pneumoconiosis
DX 42	5-1-02	12-22-03	Alexander, BCR, B	2	p/q in all lung zones; 1/1
DX 46	3-12-03	2-9-04	Cappiello, BCR, B	2	p/s in all lung zones; 1/0
DX 36	3-12-03	4-11-03	Wiot, BCR, B	2	No pneumoconiosis
DX 36	3-12-03	3-27-03	Repsher, B	2	No pneumoconiosis
DX 41	9/30/03	10/2/03	Whitehead, BCR, B	1	p/q in all lung zones; 1/0
DX 46	9/30/03	2/9/04	Cappiello, BCR, B	2	p/s in all lung zones; 1/2
EX 1	9/30/03	5/20/04	Wiot, BCR, B	1	No pneumoconiosis

B. Pulmonary Function Studies[4]

Exhibit/ Date	Physician	Age/ Height[5]	FEV_1	FVC	MVV	FEV_1/ FVC	Tracings	Comments
DX 15	Majmudar	67/70"	1.23	2.13	40	58%		Moderate obstruction

[3] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(a), (b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease.

[4] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. § 718.104(c). The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Board has held that a ventilatory study which is accompanied by only two tracings is in "substantial compliance" with the quality standards at § 718.204(c)(1). *Defore v. Alabama By-Products Corp.*, 12 BLR 1-27 (1988). The values from the FEV_1 as well as the MVV or FVC must be in the record, and the highest values from the trials are used to determine the level of the miner's disability.

[5] The miner's height was reported both as 70 and 67 inches. For purposes of determining qualifying disability values, I find that the miner's height equals 67 inches inasmuch as both Employer's and Claimant's experts (Drs. Repsher and Houser) agree in the two most recent studies that Claimant is 67 inches in height.

Exhibit/ Date	Physician	Age/ Height[5]	FEV_1	FVC	MVV	FEV_1/ FVC	Tracings	Comments
5/1/02			1.27	2.13				and moderate restriction.
DX 36	Repsher	68/67"	1.03	2.25		46%		
3/12/03			1.08	2.49		43%		
DX 41	Houser	69/67"	1.06	2.21	33.90	48%		Severe obstructive pulmonary impairment.
9/30/03			1.05	2.29	38.80	46%		
DX 16	Katzman							Acceptable
5/1/02								

C. Arterial Blood Gas Studies[6]

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 15	5/1/01	Majmudar	39	63	Resting	
			--	--	Exercise	
DX 36	3/14/03	Repsher	43.3	62.9	Resting	
			--	--	Exercise	

D. CT Scan Evidence

Dr. Repsher interpreted a March 12, 2003 CT scan of the chest. DX 36. He found left pleural thickening, question of pleural neoplasm 6 mm noncalcified right upper anterior lung nodule with another 3 mm right mid lateral lung nodule, volume loss left hemithorax probably related to post-surgical change, left renal cyst and probably hepatic cyst, and 10 and 5 mm preaortic and precardinal lymph nodes, as well as a second 2 cm preaortic lymph node and two left rib fractures, healed.

Dr. Wiot interpreted the March 12, 2003 CT scan read by Dr. Repsher as negative for coal workers' pneumoconiosis. DX 36.

E. Biopsy Evidence

A transbronchial lung biopsy of November 30, 2001 revealed anthracotic pigment in the perivascular area and no evidence of carcinoma. DX 36.

[6] Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. § 718.105(a).

A July 22, 2002 left posterolateral thoracotomy with wedge resection of left upper lobe. resulted in diagnoses of: bronchoalveolar carcinoma of lung with extension to the pleura; multiple lymph nodes with no evidence of metastatic carcinoma; no evidence of residual carcinoma, bronchial margin not involved and two of two hilar lymph nodes show no evidence of metastatic carcinoma. DX 36.

F. N4arrative Medical Evidence

Dr. Manoj Majmudar

Dr. Majmudar examined the claimant at the request of the Department of Labor on May 1, 2002. DX 15. He considered 20 years of coal mine employment as a Repair Foreman and a history of smoking one pack of cigarettes a day for 29 years before quitting in 1980. Dr. Majmudar noted symptoms of daily sputum production, cough, and dyspnea, wheezing which was bad at night, orthopnea and occasional paroxysmal nocturnal dyspnea. The miner's medical history was significant for frequent colds in 2000, pneumonia in 1999, attacks of wheezing in 2001, chronic bronchitis since December 2001, arthritis from 1950, and high blood pressure beginning in 1998. Claimant also underwent a biopsy of the lung in December 2001, had knee replacement surgery in 1989 and 1990, and back surgery in 1990. Physical examination showed normal heart and lungs with missing right pectoralis noted. He ordered an x-ray, a pulmonary function study, a blood gas study, and an EKG. Dr. Majmudar diagnosed COPD, chronic bronchitis, moderate restriction airway impairment, cor pulmonale, and a missing right chest muscle based on smoking, coal mining, and birth defect. With regard to his assessment of whether the impairment resulting from Claimant's respiratory condition would prevent him from performing his last coal mine job, Dr. Majmudar simply wrote "yes" and characterized the extent to which his conditions contributed to the impairment as "moderately." Dr. Majmudar's medical qualifications are not of record.

Dr. Lawrence Repsher

Dr. Repsher, who is board-certified in internal medicine, pulmonary disease, and as a medical examiner, examined Claimant on March 12, 2003 and reported his findings in a report dated March 31, 2003. DX 36. He noted a smoking history of 29 pack years beginning at age 18 and quitting in 1981. He also noted a work history of 20 to 22 years in underground coal mining. Physical findings including normal breath sounds, prolonged expiratory phase, and bibasilar rales (right greater than left). Chest x-ray showed no evidence of coal workers' pneumoconiosis but evidence of COPD, and probable cancer based on apparent resection of left lung tissue leaving marked distortion of the intrathoracic contents. CT scan revealed left pleural thickening, question of pleural neoplasm 6 mm noncalcified right upper anterior lung nodule with another 3 mm right mid lateral lung nodule, volume loss left hemithorax probably related to post surgical change, left renal cyst and probably hepatic cyst, and 10 and 5 mm preaortic and precordial lymph nodes, as well as a second 2 cm preaortic lymph node and two left rib fractures, healed. Spirometry revealed moderate restrictive and severe obstructive disease without significant bronchodilator response. Lung volumes revealed mild overall restrictive disease and diffusing capacity was moderately reduced, partially due to surgical loss of the left upper lobe and

underlying emphysema. Blood gas study showed mild hypoxemia, hypercarbia, and significant metabolic alkalosis of unclear etiology. Based on his examination and review of Claimant's prior medical records, Dr. Repsher's impression was: no evidence of coal workers' pneumoconiosis; severe COPD, secondary to cigarette smoking, status post left upper lobectomy for resection of bronchoalveolar cancer of the left upper lobe; possible significant mediastinal adenopathy and hepatic metastases; two noncalcified nodules, right lung; osteoarthritis of the knees, status post bilateral total knee replacement; chronic low back pain despite lumbar laminectomy in 1990; generalized osteoarthritis; and possible mild chemical diabetes mellitus. Dr. Repsher further wrote:

> As the result of the above, it is my opinion that Mr. James Pinkston is not now and never has suffered from coal workers pneumoconiosis or any other pulmonary or respiratory disease or condition, either caused by or aggravated by his work as a coal mine[er] with inhalation of coal mine dust. My reasons for these opinions are as follows:
>
> 1. He has no chest x-ray evidence of coal workers pneumoconiosis.
> 2. He has no pulmonary function test evidence of coal workers pneumoconiosis. His pulmonary function test abnormalities are purely obstructive. Coal workers pneumoconiosis, when clinically significant, are [sic] primarily a restrictive disease that may have some obstructive features.
> 3. He has no arterial blood gas evidence of coal workers pneumoconiosis. Coal workers pneumoconiosis is generally associated with normal to low pCO_2's. Mr. Pinkston has an elevated pCO_2.
> 4. He has no histologic evidence of coal workers pneumoconiosis despite having undergone a transbronchial lung biopsy on 30 November 2001 and a left upper lobectomy on 22 July 2002.
> 5. He is suffering from a number of medical diseases and conditions, some of which are potentially quite serious. However, none of these diseases or conditions could be fairly attributed to his work as a coal miner.

DX 36.

Dr. Repsher was deposed in connection with this claim on April 6, 2005 and reiterated his opinions and conclusions at that time with respect to Claimant's medical condition. EX 20.

Dr. Peter G. Tuteur

Dr. Tuteur, who is board-certified in internal medicine and pulmonary disease, reviewed medical records at the request of Employer and provided a report dated June 9, 2003. DX 36. He reviewed multiple medical records including the May 1, 2002 medical report of Dr. Majmudar, the March 31, 2003 medical report of Dr. Repsher, outpatient records from Carbondale Clinic dated February 27, 1983 through September 9, 2002, outpatient records from Dr. Larry R. Jones dated June 11, 1990 through September 2, 2002, a cardiological consultation report of Dr. Son Le dated July 16, 2002, pulmonary function studies, x-ray reports, and CT scan

reports of various dates, and biopsy results dated November 30, 2001 and July 22, 2002. Based on his review of the medical evidence, he wrote, in relevant part:

> Based on the available data, there is no convincing information to indicate the presence of coal workers' pneumoconiosis of sufficient magnitude and profusion to cause clinical symptoms, physical examination abnormalities, impairment of pulmonary function, radiographic change, or histologic identification. Yet, Mr. Pinkston clearly has a primary pulmonary disease. That condition is cigarette smoke-induced chronic obstructive pulmonary disease of a rather severe nature clearly associated with chronic bronchitis demonstrating hyperinflation on standard radiographs. This condition is caused by the chronic inhalation of tobacco smoke and with reasonable medical certainty is not related to, aggravated by, or caused by either the inhalation of coal mine dust or the development of coal workers' pneumoconiosis. In addition, Mr. Pinkston does have adenocarcinoma of the lung, another cigarette smoke-induced health problem, that was resected in July, 2002, apparently for cure. Nevertheless, the extension of the tumor to the visceral pleura is worrisome. Other health problems include hypertension usually controlled, isolated elevated serum glucose level, and multiple musculoskeletal problems requiring bilateral knee replacement, lumbar spine laminectomy, and a history of leg fracture in 1977. None of these conditions are in any way related to, aggravated by, or caused by either the inhalation of coal mine dust or the development of coal workers' pneumoconiosis.
>
> . . . .
>
> With respect to specific questions addressed in letter dated June 2, 2003, it is with reasonable medical certainty that Mr. Pinkston does not have coal workers' pneumoconiosis or any other coal mine dust-induced disease process. This statement is confirmed by the totality of available medical data including microscopic examination of resected lung tissue. Mr. Pinkston neither has "clinical", nor "medical" pneumoconiosis. He does have respiratory and pulmonary impairment. This impairment is not caused, even in part, by his work in the coal mining industry. This impairment has resulted in total and permanent disability along with arteriosclerotic heart disease, carcinoma of the lung, and spinal stenosis. Yet, neither pneumoconiosis, nor other coal mine dust-induced pulmonary processes substantially contributed to or caused his disability or impairment.

Id.

Dr. Tuteur was deposed in connection with this claim on April 6, 2005 and reiterated his opinions and conclusions at that time with respect to Claimant's medical condition. EX 19.

Dr. William Houser

Dr. Houser, who is board-certified in internal medicine, pulmonary disease, and critical care medicine, examined Claimant on September 30, 2003 and provided a report of his examination bearing that same date. DX 41. He noted complaints of daily cough with sputum production for at least the prior four to five years and complaints of dyspnea on walking about 100 feet on level ground or climbing one flight of stairs. Dr. Houser noted outpatient treatment for both bronchitis and pneumonia in the past and no hospitalization or emergency room visits for respiratory problems. He noted that Claimant's respiratory symptoms were aggravated by exposure to dust, smoke, fumes, perfume, hairspray, cologne and other respiratory irritants. Dr. Houser also noted that Claimant had a left upper lobectomy performed for carcinoma of the lung the prior year. He recorded a smoking history of about one pack of cigarettes per day for 30 years, ceasing in 1981. He also noted underground coal mine work from 1969 through 1990 as a mechanic and a supervisor with some welding. Physical examination revealed the chest was clear to percussion with equal movement bilaterally, scattered wheezing and rhonchi on ausculation (primarily on expiration), and no bronchial breath sounds, rales, or pleural rubs. Dr. Houser noted that a pulmonary function test revealed severe airway obstruction with no significant response to bronchodilator. A chest x-ray revealed postoperative changes on the left with at least one old rib fracture on the left. Dr. Houser's assessment was: severe chronic obstructive pulmonary disease ("COPD"); status post left upper lobectomy for carcinoma of the lung; chronic bronchitis; obesity; degenerative arthritis; and status post lumbar laminectomy and bilateral knee replacement. With regard to etiology, Dr. Houser wrote:

> Mr. Pinkston has evidence of chronic bronchitis and severe chronic obstructive pulmonary disease. Etiology of these conditions is most likely related to former smoking and former coal mine employment. He is currently not working, therefore, he will have [no] additional exposure to coal and rock dust. He should also avoid exposure to smoke and fumes.

Id. Dr. Houser noted that he had requested a copy of the lung pathology slides from Carbondale with reference to any possible changes of pneumoconiosis histologically.

On November 21, 2003, Dr. Houser wrote a letter supplementing his September 30, 2003 report. DX 41. The letter states, in relevant part:

> I believe Mr. Pinkston is permanently and totally disabled. This would include light and sedentary work and certainly he is physically unable to perform his job as an underground foreman over maintenance and repairs of heavy equipment which is classified as heavy manual labor. He easily qualifies for disability under the Social Security regulation. Using the AMA Guidelines for Permanent Impairment due to respiratory disorders, he has class IV (50-100% impairment of the whole person). The factors causing his respiratory disability include chronic obstructive pulmonary disease, chronic bronchitis, and coal workers' pneumoconiosis. The coal workers' pneumoconiosis is secondary to exposure to coal and rock dust arising from his 19 ½ years employment as a coal miner. I believe exposure to coal and rock dust is also a significant contributing factor to

> the development of his chronic obstructive pulmonary disease and chronic bronchitis.

Id.

Dr. Robert A. C. Cohen

Dr. Cohen, who is a certified NIOSH B-reader and board-certified in internal medicine, pulmonary disease, advanced cardiac life support, and as a medical examiner, reviewed the available medical evidence with respect to this claim at Claimant's request and prepared a written report dated December 10, 2004 outlining his findings and conclusions. CX 1. Among the records he reviewed were the May 1, 2002 report by Dr. Majmudar, the March 31, 2003 report by Dr. Repsher, the June 9, 2003 report by Dr. Tuteur, and multiple treatment, hospitalization, and objective test results from chest x-rays, pulmonary function studies, arterial blood gas tests, and biopsies. He concluded, that Claimant suffers from coal workers' pneumoconiosis based on: his 19 years of underground coal mine employment; symptoms which are consistent with chronic lung disease including cough, sputum production, dyspnea, and wheezing since 1990; physical examinations over the last ten years which consistently showed signs of chronic lung disease including wheezing, decreased breath sounds, rales and rhonchi; spirometry results showing severe obstructive lung disease with diffusion impairment and abnormal gas exchange; x-ray evidence which is positive for interstitial lung disease and pneumoconiosis; and no history of any other occupational exposure which could cause coal workers' pneumoconiosis or obstructive lung disease. According to Dr. Cohen:

> His only other significant exposure was his minimal exposure to tobacco smoke. It is well known that coal dust like tobacco smoke can cause or contribute to obstructive impairment like that in Mr. Pinkston.

Id. Dr. Cohen opined that Claimant's severe obstructive lung disease would preclude him from engaging in the physical exertion required of his prior coal mine employment and that his long-term exposure to coal dust is a significant contributing cause of his pulmonary disability which he stated is manifested by moderate restrictive and severe obstructive defect. He also found Claimant's tobacco smoke exposure to be a significant contributing factor to his impairment.

On June 28, 2005, Claimant's counsel filed Dr. Cohen's supplemental report dated June 13, 2005 in which Dr. Cohen responded to the deposition testimony of Drs. Tuteur and Repsher. CX 2. According to Dr. Cohen, Drs. Tuteur and Repsher disagree with his opinion that Claimant's COPD is related to both his smoking and coal dust exposure "based on their unscientific calculation of statistical odds for coal dust contributing to obstruction." *Id*. at 1. Dr. Cohen wrote:

> They prefer to conclude that occupational exposure is not connected to this man's severe obstruction because in their minds the odds are against it. That line of reasoning requires them to misconstrue the results of landmark studies showing that loss of lung function from occupational exposure is definitely clinically significant. They also had to rework the findings of the studies in order to make

> their point. They did not assess this patient's medical condition based on the medical authority that involved scientifically accepted design, methodology and analysis.

Ibid. After noting specific criticisms of the various opinions offered by Drs. Tuteur and Repsher, Dr. Cohen further wrote:

> In conclusion, my review of the additional information from Drs. Tuteur and Repsher has not changed my opinion. I still believe that the sum of the medical evidence in conjunction with this patient's work history indicates that this patient's 19 years of coal dust exposure and his smoking history were significantly contributory to the development of his moderate restrictive lung disease, sever obstructive lung disease and diffuse impairment.

Id. at 4.

G. Hospital and Treatment Records

The record contains multiple medical records submitted by Employer from a variety of sources including the following:

Director's Exhibit 36

Treatment records from Dr. Larry R. Jones dated from 1993 – 2002.

Cardiac consultation report of Dr. Son Le dated July 16, 2002 with associated test results. Impression noted by Dr. Le was: cardiac evaluation before resection of lung mass located in the left upper lobe; left upper lobe mass; history of hypertension, currently under control; history of chronic bronchitis and black lungs; chronic productive cough and dyspnea, probably secondary to his pulmonary disease; left sided blindness.

Treatment records from Carbondale Clinic dated 2001 – 2002.

Treatment and related records from Memorial Hospital of Carbondale for period July and August 2002.

Treatment and related records from Harrisburg Medical Center for period 1991 through 2002.

Hospitalization records from Memorial Hospital of Carbondale for November-December 2001 and July 2002.

Employer's Exhibit 3

Diagnostic imaging reports from Memorial Hospital of Carbondale dated 2002 – 2003.

Employer's Exhibit 4

PET scan records from Southern Illinois Cancer Center for September and December, 2004.

Employer's Exhibit 5

Consultation report of Dr. Moises B. Domingo, Radiation Oncologist, dated October 11, 2002 with attached June 10, 2003 letter from Dr. Luis A. Concepcion.

Employer's Exhibit 6

Hospitalization records from Memorial Hospital of Carbondale for November 2004.

Employer's Exhibit 7

Treatment records from Dr. James Gould of Oncology Associates of Western Kentucky for 2003 – 2004.

Employer's Exhibit 8

Treatment records from Harrisburg Medical Center from July 2002 through October 6, 2003.

Employer's Exhibit 9

Treatment records from Harrisburg Medical Center from July 2002 through October 6, 2003.

Employer's Exhibit 10

Treatment records from Memorial Hospital of Carbondale from June 2004 to November 2004.

Employer's Exhibit 11

Treatment records from Dr. Larry R. Jones from 2001 – 2003.

Employer's Exhibit 12

Treatment records from Memorial Hospital of Carbondale for 2004.

Employer's Exhibit 13

Treatment records from Dr. Chirag Dave for 2001 – 2004.

Employer's Exhibit 14

Treatment records from Memorial Hospital of Carbondale for 2002.

Employer's Exhibit 15

Treatment records from Dr. James Gould of Oncology Associates of Western Kentucky for 2002 – 2003.

Employer's Exhibit 16

Treatment records from Dr. Chirag Dave for 2001 – 2003.

Employer's Exhibit 17

Treatment records from Dr. Larry R. Jones for 2003 – 2004.

DISCUSSION AND APPLICABLE LAW

A subsequent claim for benefits "shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement . . . has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. § 725.309(d). To be entitled to benefits under Part 718, a claimant must establish by a preponderance of evidence that (1) he has pneumoconiosis, (2) the pneumoconiosis arose from his coal mine employment, (3) he is totally disabled, and (4) the total disability is due at least in part to pneumoconiosis. *Gee v. M.G. Moore & Sons*, 9 BLR 1-4 (1986).

As noted above, since Claimant's original claim was denied by reason of abandonment, he is deemed not to have established any applicable condition of entitlement. In order to prevail in this subsequent claim, he must therefore establish that he has pneumoconiosis which arose from his coal mine employment and that he is totally disabled at least in part due to that disease.

Pneumoconiosis and Causation

The new regulatory provisions at 20 C.F.R. § 718.201 contain a modified definition of "pneumoconiosis" and they provide the following:

> (a) For the purposes of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the

lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coalmine dust exposure.

20 C.F.R. § 718.201. Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Each shall be addressed in turn.

Under section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc); *Casella v. Kaiser Steel Corp.*, 9 BLR 1-131 (1986). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP,* 12 BLR 1-6 (1988); *Clark*, 12 BLR 1-149 (1989).

The record contains ten interpretations of three chest x-rays. Of these interpretations, one was read for quality purposes only. Of the remaining nine interpretations, five were found negative and four were found positive for pneumoconiosis.

With respect to the May 1, 2002 x-ray, that film was interpreted as negative for pneumoconiosis by Dr. Wiot, a dually-qualified physician, and as positive for pneumoconiosis by Dr. Alexander, who is also a dually-qualified physician. Dr. Majmudar, whose qualifications are not of record, interpreted the May 1, 2002 x-ray as negative for pneumoconiosis, although he noted the presence of some parenchymal abnormalities in both lower lobes consistent with pneumoconiosis.[7]

[7] Dr. Majmudar identified small type "p/r" and "u" opacities as being present in a "Category 0/1" profusion. A category 0/1 profusion indicates only a negligible presence of the disease and does not support a finding of pneumoconiosis under the Act or regulations.

The March 12, 2003 film was interpreted by Dr. Cappiello, another dually-qualified physician, as positive for the disease and as negative by Dr. Wiot and Dr. Repsher, who is a B-reader.

The September 30, 2003 x-ray was found to be positive for pneumoconiosis by two dually-qualified physicians, Drs. Whitehead and Cappiello, and negative for pneumoconiosis by Dr. Wiot.

I give lesser weight to Dr. Majmudar's negative interpretation of the May 1, 2002 x-ray since there is no evidence in the record which provides any basis upon which to assess his qualifications to interpret chest x-ray films. Furthermore, I do not find, as Employer would have me do, that Dr. Wiot's credentials as a professor of radiology and his involvement in the development of the B-reader program automatically entitle his opinion to more weight than the opinions of Drs. Whitehead, Alexander, and Cappiello. Dr. Whitehead is a graduate of the Indiana University School of Medicine, has been a board-certified radiologist since June of 1981, and has taught radiology at both Indiana University Medical Center and the University of Southern Indiana. DX 41. Dr. Alexander is a graduate of New York Medical College, was board-certified in diagnostic radiology in 1982, was further board-certified with special competence in nuclear radiology in 1986, and taught radiology at the University of Maryland. DX 42. Similarly, Dr. Cappiello is a graduate of Georgetown University School of Medicine, has been board-certified in radiology since 1978, and taught radiology at the Albert Einstein College of Medicine in New York City. DX 46. I find that each of these physicians, all of whom are certified NIOSH B-readers, are highly qualified and that their interpretations of Claimant's x-rays are entitled to no less weight than the contrary interpretations of Dr. Wiot. Furthermore, given the consistent findings of pneumoconiosis by these dually-qualified physicians of each of the three x-rays of record, particularly the two positive readings by Drs. Cappiello and Whitehead of the most recent film from September 30, 2003, I find that the x-ray evidence viewed in its entirety tends to establish the existence of pneumoconiosis under § 718.202(a)(1).

Under Section 718.202(a)(2), biopsy or autopsy evidence may establish pneumoconiosis. Black pigment in the lungs, standing alone, does not constitute a finding of pneumoconiosis. On the other hand, observations of black pigment with associated fibrosis qualify as a diagnosis of the disease. A finding of anthracosis falls within the definition of pneumoconiosis at § 718.201(a)(1).

The transbronchial biopsy of November 30, 2001 revealed anthracotic pigment in the perivascular area and no evidence of carcinoma. Neither it, nor the July 22, 2002 left posterolateral thoracotomy with resection of Claimant's left upper lobe, resulted in a diagnosis of pneumoconiosis. I therefore find that this evidence does no support a finding of the disease.

Under Section 718.202(a)(3), the existence of pneumoconiosis may be established if one of the presumptions at Sections 718.304 to 718.306 applies. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively.

Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. If established, section 718.304 provides an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis. Complicated pneumoconiosis is established by x-rays classified as Category A, B, or C, or by an autopsy or biopsy, which yields evidence of massive lesions in the lung or nodules in the lung that would equate to a one centimeter or greater opacity on x-ray. In this case, there is no x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis.

Section 718.202(a)(4) provides the fourth and final way to prove that the miner has or had pneumoconiosis. Under this section, Claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffered from pneumoconiosis. Although the x-ray evidence may be negative for pneumoconiosis, a physician's reasoned opinion may support the presence of the disease if it is supported by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms, and a patient's history. *See Hoffman v. B & G Construction Co.*, 8 BLR 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Buffalo v. Director, OWCP*, 6 BLR 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp.*, 2 BLR 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for the fact-finder to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 BLR 1-1292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1985); *Smith v. Eastern Coal Co.*, 6 BLR 1-1130 (1984); *Duke v. Director, OWCP*, 6 BLR 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 BLR 1-601 (1982).

Drs. Majmudar, Houser, and Cohen concluded that Claimant has pneumoconiosis which was caused, at least in part, by his coal mine employment. Drs. Tuteur and Repsher, in contrast, concluded that Claimant's pulmonary impairment is caused solely by his prior cigarette smoking. After a thorough review of each of these opinions, I find, for the reasons set forth below, that the medical opinion evidence supports a finding of pneumoconiosis caused by coal mine employment.

After reviewing the available medical evidence, Dr. Cohen concluded that Claimant's "long-term exposure to coal dust is a significant contributing cause of his pulmonary disability as manifested by moderate restrictive and severe obstructive defect." CX 1 at 10. Dr. Cohen also

recognized that Claimant's prior cigarette smoking was a significant contributing factor regarding his pulmonary disability. *Ibid*. His diagnosis is supported by Claimant's pulmonary function test results, which revealed severely reduced FEV_1 and FEV_1/FVC ratios, and by findings of medical and scientific studies confirming a link between occupational exposure to coal dust and obstructive lung disease and emphysema. *Id*. at 10-13. According to Dr. Cohen, "[t]he development of obstructive lung disease from exposure to coal dust is not far less frequent than that from exposure to cigarette smoking." *Id*. at 13. Studies have confirmed an elevated risk of death from pneumoconiosis, chronic bronchitis, and emphysema based on cumulative exposures to coal dust, and increased mortality from these diseases "correlated with exposure and remained significant after controlling for age, smoking, and removing cases with concomitant pneumoconiosis." *Ibid*. As Dr. Cohen wrote:

> All of these highly sophisticated scientific studies of thousands of miners consistently show a relationship between coal dust exposure and declines in lung function: dust-caused impairment is at a level comparable to that of cigarette smoke and the effect of dust exposure on FEV_1 is highly significant in both smokers and non-smokers. Once again, the results show a significant relationship between loss of lung function and coal dust exposure just like that in Mr. Pinkston's case. He had significant exposure while working as a miner for 25 years, and his PFTs demonstrate a significant decline in pulmonary function. Clearly, coal dust had deleterious effects on the pulmonary function of coal miners. . . .

Id. at 14. Dr. Cohen is a graduate of Northwestern University Medical School, is a NIOSH certified B-reader, is board certified in internal medicine and pulmonary disease, and serves as, *inter alia*, the Medical Director of Pulmonary Physiology and Rehabilitation at Cook County Hospital, the Medical Director of the Black Lung Clinics Program at Cook County Hospital, and the Chief of the Respiratory Studies Branch of the Great Lakes Center for Occupational and Environmental Health at the University of Illinois School of Public Health, all of which are in Chicago, Illinois. CX 1 at 17-32. I find Dr. Cohen's opinion to be thorough, well documented, well reasoned, and supported by the objective medical evidence of record. His opinion is also consistent with, and supported by, the opinions of Drs. Majmudar and Houser, both of whom previously examined the miner. DX 15, 41.

In contrast to Dr. Cohen's opinion, Dr. Repsher, Employer's expert, examined Claimant on March 12, 2003, reviewed the available medical evidence, and authored a report dated March 31, 2003 in which he opined that Claimant suffered from severe COPD but not coal workers' pneumoconiosis. DX 36. Dr. Repsher wrote:

> [I]t is my opinion that Mr. James Pinkston is not now and never has suffered from coal workers pneumoconiosis or any other pulmonary or respiratory disease or condition, either caused by or aggravated by his work as a coal mine[er] with inhalation of coal mine dust.

Ibid. He cited, as the reasons for his opinion, the lack of chest x-ray evidence of coal workers' pneumoconiosis, and no pulmonary function, arterial blood gas, or histologic evidence of the

disease. *Ibid*. He noted that Claimant's pulmonary function test abnormalities were purely obstructive and wrote that coal workers' pneumoconiosis was "primarily a restrictive disease that may have some obstructive features." *Ibid*. He further noted that Claimant's elevated pCO_2 level shown on arterial blood gas testing was inconsistent with a finding of pneumoconiosis which was generally associated with a normal to low pCO_2 level. *Ibid*.

During his deposition, Dr. Repsher testified that he graduated from the University of Rochester School of Medicine, is a NIOSH certified B-reader, and is board-certified in internal medicine and pulmonary disease. EX 20 at 3, 4, 6. Dr. Repsher stated that inhalation of coal dust can cause only "very mild" obstruction. *Id*. at 11. He further testified that it is "very uncommon" that pneumoconiosis is both a latent and progressive disease, and described the medical literature discussing the latency and progressivity of pneumoconiosis as "very highly controversial." *Id*. at 11, 41. He also characterized the literature relied on by the Department of Labor when it amended its black lung regulations as "contradictory," and he described NIOSH as "biased" and the Department of Labor as "political." *Id*. at 59, 63. He disagreed with the 2002 position statement of the American Thoracic Society, of which he is a member, with respect to coal miners developing COPD at a rate equivalent to smokers. *Id*. at 61, 76.

Dr. Repsher testified that, based on his examination of the miner, he determined that Claimant had ischemic heart disease based on symptoms of angina, left ventricular congestive heart failure, and the results of a thallium treadmill test. *Id*. at 22. He also stated that Claimant had hypertension which was consistent with peripheral arterial atherosclerosis. *Id*. at 27. According to Dr. Repsher, the results of Claimant's spirometry were consistent with severe COPD and, although the "raw" numbers showed restriction, those results were actually caused by "pseudorestriction" which results from increases in residual air volume in the lung that ultimately encroach on total air volume. *Id*. at 34. He found no evidence of coal workers' pneumoconiosis and stated that he was able to differentiate between Claimant's COPD, which he determined was caused by smoking cigarettes, and COPD caused in others by the inhalation of coal mine dust, based on the results of Claimant's arterial blood gas test results and statistical studies which show there is no clinically significant difference between groups of workers exposed to coal dust and workers who are not so exposed. *Id*. at 42-43. Dr. Repsher subsequently admitted that objective tests, such as spirometry and blood gas tests, do not establish the cause of the disease. *Id*. at 74-75. When asked what allowed him to determine that this Claimant's exposure to coal mine dust, which can cause obstructive lung disease, was not a factor in his COPD, Dr. Repsher simply stated it was the statistical relationship between smokers who develop the disease and nonsmoking miners who develop the disease. *Id*. at 77. He subsequently acknowledged that he could not rule out coal dust exposure as a causative factor in Claimant's COPD if he accepts the fact that inhalation of coal mine dust can result in COPD, although he said "it would be very unlikely." *Id*. at 80. He also acknowledged that he could not rule out the possibility that Claimant's exposure to coal mine dust was a substantial cause of his COPD inasmuch as coal mine dust can cause obstruction and Claimant had sufficient exposure to both coal mine dust and smoking to cause obstruction. *Id*. at 82.

Dr. Tuteur, Employer's other expert, reviewed the available medical evidence and opined that Claimant did not have coal workers' pneumoconiosis but did have cigarette smoke-induced COPD manifested by chronic bronchitis and airflow obstruction which was not related to,

aggravated by, or caused by, the inhalation of coal mine dust. DX 36. According to Dr. Tuteur, chronic bronchitis can occur from chronic inhalation of coal mine dust but it occurs rarely among non-smoking miners. *Ibid*. In contrast, he says, chronically smoking non-miners develop this condition approximately 20% of the time. *Ibid*. Based on these statistics, he believes to a reasonable degree of medical certainty that Claimant's condition is not due to inhalation of coal mine dust and is instead due to the inhalation of tobacco smoke. *Ibid*.

At his deposition, Dr. Tuteur testified that he is a graduate of the University of Illinois School of Medicine, is board-certified in internal medicine and pulmonary disease, and is a full-time tenured professor of medicine at the Washington University in St. Louis, Missouri. EX 19 at 4, 6. He stays current with medical literature in the field of pulmonology through his work with the university, by reading medical journals, and by his involvement in patient care. *Id*. at 11-12.

Based on his review of the medical evidence, Dr. Tuteur determined that Claimant developed three cigarette smoke-induced health problems: COPD; adenocarcinoma; and arteriosclerotic heart disease (or coronary artery disease). *Id*. at 17-18. He found no clinical, physiologic, radiographic, or pathologic evidence of legal or medical coal workers' pneumoconiosis. *Id*. at 18, 44. Dr. Tuteur testified that it was not possible to differentiate the cause of COPD with reasonable medical certainty, but he concluded that Claimant's COPD was not coal dust related since, as a smoker, he had a 20% risk of developing the disease and exposure to coal mine dust in non-smokers results in COPD less than 1% of the time. *Id*. at 19, 42-43. He further testified that Claimant's pulmonary function was essentially stable in 2001 and 2002, there was no evidence of coal workers' pneumoconiosis from the November 2001 biopsy and July 2002 lung resection, and the waxing and waning of Claimant's symptoms over time was indicative of cigarette smoke-induced COPD. *Id*. at 23, 24-25, 28, 30. Claimant's condition was, according to Dr. Tuteur, expected to get worse because of age-related changes superimposed on prior damage to the lungs due to cigarettes. *Id*. at 33. He noted there was evidence of mild impairment of gas exchange at rest and determined that Claimant had emphysema, heart disease, chronic bronchitis "and the potential of left ventricular dysfunction and, potentially, some pulmonary hypertension due to the left ventricular dysfunction." *Id*. at 37.

Dr. Cohen reviewed the deposition testimony of Drs. Tuteur and Repsher and prepared a supplemental report dated June 13, 2005 in which he disputed each of their conclusions. CX 2.

Dr. Cohen states, with respect to Dr. Tuteur, that he failed to cite any medical or scientific authority for his statements that 20% of smokers and only 1% or less of nonsmoking miners develop COPD. Dr. Cohen stated that he knows of no authority that would confirm either statement, and he asserts that Dr. Tuteur simply "uses artificial statistics created out of thin air that for every patient will always require a false conclusion that the cause is only smoking. . . . *Id*. at 1. In contrast, he notes that the medical research discussed in his own report contradicts Dr. Tuteur's opinion and in fact shows that the decline in lung function is similar between individuals who are exposed to coal dust and cigarette smoking. *Ibid*. He also notes that Dr. Tuteur admitted he would relate Claimant's COPD to coal dust exposure if he had never smoked, and states "there is nothing in the data set to suggest that the remote smoking history accounts for the rapid decline in lung function more than 20 years after smoking cessation." *Id*. at 2.

According to Dr. Cohen, the waxing and waning of Claimant's symptoms are, contrary to Dr. Tuteur's opinion, typical of obstructive lung diseases, including those related to coal dust exposure, and Claimant's worsening condition simply cannot be attributed to smoking since he quit ten years before the symptoms developed and long before his condition rapidly deteriorated. *Ibid*. Dr. Cohen also disagreed with Dr. Tuteur's conclusion that Claimant suffered from heart disease that would explain his pulmonary impairment, and he disputed Dr. Tuteur's conclusion that pulmonary function studies showed no restriction. *Id*. at 2-3. According to Dr. Cohen: "I reviewed the data again and my opinion remains that the patient has moderate restriction based on reduced FVC confirmed by [total lung capacity], consistent with positive x-ray interpretations." *Id*. at 3. With respect to Dr. Tuteur's disagreement with the medical and scientific literature, he further wrote:

> My review of the relevant literature in my earlier report discusses the medical authority. [Dr. Tuteur's] distortion of the research has not been submitted for scientific testing or critical review. On the other hand, the research conducted by the internationally known and respected scientists and researchers that I referenced has been scrutinized, published and applauded. There is no published account that disputes or refutes any of it.

Ibid.

With respect to Dr. Repsher, Dr. Cohen disputes his diagnosis of ischemic heart disease based on symptoms and a thallium treadmill test in 1999. *Id*. at 3. He notes that Claimant underwent extensive testing in 2002 prior to surgery which showed no ischemic changes and a normal ejection fraction indicating no functionally significant heart disease or impairment. *Ibid*. Dr. Cohen also took issue with Dr. Repsher's assertion that he could determine Claimant's COPD was related to smoking based on abnormal blood gas studies. *Ibid*. According to Dr. Cohen, "[n]o objective test, including this one, reveals the cause of obstruction, only its presence." *Ibid*. He also notes that Dr. Repsher's claim that miners with medical pneumoconiosis do not have clinically significant obstruction is refuted by the medical literature cited in Dr. Cohen's prior report. *Ibid*. Dr. Cohen wrote: Like Dr. Tuteur, Dr. Repsher disagrees with the medical literature I referenced in my earlier report regarding coal dust exposure and obstruction . . . ." *Id*. at 3-4.

After a thorough review of the reports and testimony of each of these three physicians regarding the presence and cause of Claimant's COPD, I am most persuaded by the opinion of Dr. Cohen. I find that his opinion is supported by objective medical evidence, is thoroughly documented, well reasoned, rational, and consistent with prevailing medical opinion regarding the development of chronic obstructive lung disease as adopted by the Department of Labor in the amended regulations. In particular, I agree with Dr. Cohen's conclusion that the opinions of Drs. Tuteur and Repsher are greatly diminished by their reliance on statistics regarding the percentage of smokers who develop COPD versus nonsmoking miners who do not develop the disease. Dr. Tuteur expressly acknowledged that if Claimant had never smoked he would attribute Claimant's COPD to the inhalation of coal dust. He further acknowledged that there is no way to objectively differentiated between COPD caused by smoking and that which is caused by coal dust. Thus, the only basis for his conclusion that Claimant's COPD was caused by

smoking is his reliance on an unsupported assertion that 20% of smokers develop the disease while only 1% or less of nonsmoking miners develop COPD. Even if this assertion is accepted as accurate, he does *not* explain why *this* Claimant's COPD must be attributed to his smoking, which he stopped in January 1981, and not his 19 years of exposure to coal mine dust, which ended eight years later. I also note that Dr. Teuter's views on the development of COPD among coal mine workers are clearly critical of the contrary views of medical professionals who have published studies accepted by NIOSH as accurate and upon which the Department of Labor relied when it promulgated its revised regulations in 2001. *See*, *e.g.*, EX 18 at Tabs 1, 4, 7, 8, 19, 40-41; EX 19 at 48-53 and Respondent's Exhibit 1 attached thereto. Dr. Repsher similarly describes the conclusions in the literature referenced by NIOSH and the Department of Labor as "contradictory," characterizes NIOSH as a "biased" organization and the Department of Labor as "political," and disagrees with the 2002 position statement of the American Thoracic Society, of which he is a member, regarding the development of obstructive pulmonary diseases resulting from exposure to coal mine dust. EX 20 at 59, 61, 63. However, Dr. Repsher expressly acknowledged, albeit grudgingly, that he could not rule out the possibility that Claimant's exposure to coal mine dust was a substantial cause of his COPD.

Based on the foregoing, I find that Claimant has established by a preponderance of the evidence that he has a chronic obstructive pulmonary disease, *i.e.*, pneumoconiosis, arising out of his 19 years of coal mine employment.[8]

Total Disability

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(2). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 BLR 1-11, 1-15 (1991). Section 718.204(b)(2) provides several criteria for establishing total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195, 1-198 (1987).

Under Sections 718.204(b)(2)(i) and (b)(2)(ii), total disability may be established with qualifying pulmonary function studies or arterial blood gas studies.[9]

All ventilatory studies of record, both pre-bronchodilator and post-bronchodilator, must be weighed. *Strako v. Ziegler Coal Co.*, 3 BLR 1-136 (1981). To be qualifying, the FEV_1 as well as the MVV or FVC values must equal or fall below the applicable table values. *Tischler v.*

[8] Because Mr. Pinkston has established over ten years of coal mine employment, he is entitled to a rebuttable presumption that his pneumoconiosis arose from coal mine employment. *See* 20 C.F.R. § 718.203(b). The employer has failed to rebut that presumption.

[9] A "qualifying" pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(b)(2)(i) and (b)(2)(ii). A "non-qualifying" test produces results that exceed the table values.

Director, OWCP, 6 BLR 1-1086 (1984). I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 BLR 1-154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 BLR 1-131 (1986). In assessing the reliability of a study, I may accord greater weight to the opinion of a physician who reviewed the tracings. *Street v. Consolidation Coal Co.*, 7 BLR 1-65 (1984). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP* 7 BLR 1-414 (1984). If a study is accompanied by three tracings, then I may presume that the study conforms unless the party challenging conformance submits a medical opinion in support thereof. *Inman v. Peabody Coal Co.*, 6 BLR 1-1249 (1984). Also, little or no weight may be accorded to a ventilatory study where the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 BLR 1-1141 (1984); *Runco v. Director, OWCP*, 6 BLR 1-945 (1984); *Justice v. Jewell Ridge Coal Co.*, 3 BLR 1-547 (1981).

The record contains three pulmonary function tests. DX 15, 36, 41. All three pulmonary function studies produced results showing that Claimant is totally disabled. I thus find that this evidence supports a finding of total disability.

All blood gas study evidence of record must be weighed. *Sturnick v. Consolidation Coal Co.*, 2 BLR 1-972 (1980). This includes testing conducted before and after exercise. *Coen v. Director, OWCP*, 7 BLR 1-30 (1984); *Lesser v. C.F.&I. Steel Corp.*, 3 BLR 1-63 (1981). In order to render a blood gas study unreliable, the party must submit a medical opinion that a condition suffered by the miner, or circumstances surrounding the testing, affected the results of the study and, therefore, rendered it unreliable. *Vivian v. Director, OWCP*, 7 BLR 1-360 (1984) (miner suffered from several blood diseases); *Cardwell v. Circle B Coal Co.*, 6 BLR 1-788 (1984) (miner was intoxicated). Similarly, in *Big Horn Coal Co. v. Director, OWCP [Alley]*, 897 F.2d 1045 (10th Cir. 1990) and *Twin Pines Coal Co. v. U.S. DOL*, 854 F.2d 1212 (10th Cir. 1988), the court held that the administrative law judge must consider a physician's report which addresses the reliability and probative value of testing wherein he or she attributes qualifying results to non-respiratory factors such as age, altitude, or obesity.

The two arterial blood gas studies comport with the quality standards. Accordingly, I find them valid. The study conducted on May 1, 2001 by Dr. Majmudar produced non-qualifying values. DX 15. The study conducted on March 14, 2003 by Dr. Repsher also produced non-qualifying values. DX 36. I thus find that the blood gas study evidence does not support a finding of total disability.

Section 718.204(b)(2)(iii) provides that a claimant may prove total disability through evidence establishing cor pulmonale with right-sided congestive heart failure. While the examination report of Dr. Majmudar notes cor pulmonale among the diagnoses listed in that report (DX 15), he provides no explanation for his diagnosis of that condition. No other reviewing or examining physician diagnosed cor pulmonale. I thus find that the weight of the evidence fails to establish total disability based on cor pulmonale with right-sided congestive heart failure.

Under Section 718.204(b)(2)(iv), total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable and gainful work.

The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms, and a patient's history. *See Hoffman v. B&G Construction Co.*, 8 BLR 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Buffalo v. Director, OWCP*, 6 BLR 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp.*, 2 BLR 1-130 (1979). A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc).

In assessing total disability under § 718.204(b)(2)(iv), the administrative law judge, as the fact-finder, is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.* 227 F.3d 569 (6th Cir. 2000) (a finding of total disability may be made by a physician who compares the exertional requirements of the miner's usual coal mine employment against his physical limitations); *Schetroma v. Director, OWCP*, 18 BLR 1-19 (1993) (a qualified opinion regarding the miner's disability may be given less weight). *See also Scott v. Mason Coal Co.*, 14 BLR 1-37 (1990) (en banc on recon.). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a prima facie finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(c)(2). *Taylor v. Evans & Gambrel Co.*, 12 BLR 1-83 (1988).

Dr. Majmudar examined Claimant on May 1, 2002 and concluded that he was incapable of performing his last coal mine job. DX 15. Dr. Repsher examined Claimant on March 12, 2003 and diagnosed moderate restrictive and severe obstructive pulmonary disease. DX 36. Dr. Tuteur reviewed the available medical evidence and authored a report dated June 9, 2003 in which he concluded that Claimant had a total and permanent pulmonary impairment. DX 36. On September 30, 2003, Dr. Houser examined Claimant and reported a diagnosis of severe COPD. DX 41. His November 21, 2003 letter supplementing his report states that Claimant is permanently and totally disabled. *Ibid*. Finally, Dr. Cohen reviewed the available medical evidence of record and noted in his December 10, 2004 report that Claimant has severe obstructive lung disease which would preclude him from engaging in the physical exertion required of his prior coal mine employment. CX 1. The opinions of each of these physicians are well documented and reasoned. They are supported by the underlying objective evidence. For these reasons, and because the opinions are unanimous, I find that the medical opinion evidence establishes total disability.

Based on the foregoing, I find that Claimant has established, by a preponderance of all the relevant evidence, that he is totally disabled. All the narrative reports and all of the pulmonary function tests weigh in favor of a finding of total disability. Accordingly, I find Claimant is totally disabled.

Total Disability Due to Pneumoconiosis

Unless one of the presumptions set forth in 20 C.F.R. §§ 718.304, 718.305, or 718.306 is applicable, a miner must establish that his total disability is due, at least in part, to pneumoconiosis under § 718.204. That regulation provides, in relevant part:

> (c)(1) *Total disability due to pneumoconiosis defined*. A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:
> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.
>
> (2) Except as provided in § 718.305 and paragraph (b)(2)(iii) of this section, proof that the miner suffers or suffered from a totally disabling respiratory or pulmonary impairment as defined in paragraphs (b)(2)(i), (b)(2)(ii), (b)2)(iv) and (d) of this section shall not, by itself, be sufficient to establish that the miner's impairment is or was due to pneumoconiosis. Except as provided in paragraph (d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report.

20 C.F.R. § 718.204(c).

Section 718.304 of the regulations provides an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if complicated coal workers' pneumoconiosis is established. 20 C.F.R. § 718.304. Since the evidence of record does not establish that Claimant suffers from complicated coal workers' pneumoconiosis, this presumption is inapplicable.

Under Section 718.305, a miner employed for fifteen years or more in underground coal mining is entitled to a rebuttable presumption that his totally disabling respiratory or pulmonary impairment is due to pneumoconiosis despite negative chest x-ray evidence. 20 C.F.R. § 718.305. This presumption may only be rebutted by showing that the miner does not have pneumoconiosis or his respiratory or pulmonary impairment did not arise out of, or in connection with, his coal mine employment. *Ibid*. As noted above, Claimant has established that he worked at least 19 years in underground coal mine employment. He is thus entitled to the rebuttable presumption that his totally disabling respiratory impairment is due to pneumoconiosis.

Drs. Repsher and Tuteur assert that Claimant's respiratory impairment is due solely to his cigarette smoking. In contrast, Drs. Majmudar, Houser and Cohen have all attributed Claimant's totally disabling respiratory impairment to smoking *and* exposure to coal mine dust during his employment as a coal miner. For all the reasons set forth above, I find that the opinions of Drs. Repsher and Tuteur regarding the etiology of Claimant's respiratory impairment are entitled to less weight than the contrary opinions of Drs. Majmudar, Houser and Cohen. Employer has thus failed to rebut the presumption that Claimant's respiratory impairment is due to pneumoconiosis.

Conclusion

In sum, the evidence establishes that Claimant suffers from pneumoconiosis caused by his coal mine employment and that he is totally disabled due to pneumoconiosis. Accordingly, the claim of James J. Pinkston is granted.

Date of Onset

In a case such as this, in which the evidence does not establish the month of the onset of total disability, benefits are payable beginning with the month during which the claim was filed. 20 C.F.R. § 725.303(d). In this case, Claimant filed the instant claim on February 12, 2002.

Attorney's Fees

No award of attorney's fees for services to Claimant is made herein, as no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. Her attention is directed to §§ 725.365 and 725.366 of the Regulations. A service sheet showing service upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of JAMES J. PINKSTON for black lung benefits under the Act is hereby GRANTED, and it is hereby ORDERED that PEABODY COAL COMPANY, the Responsible Operator, shall pay to Claimant, JAMES J. PINKSTON, all augmented benefits to which he is entitled under the Act, commencing February 12, 2002.

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STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty days from the date of this decision by filing a notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. This decision shall be final thirty days after the filing of this decision with the district director unless appeal proceedings are instituted. 20 C.F.R. § 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.